Delta Dental of Iowa

DELTA DENTAL PPO PLUS PREMIER®

INDIVIDUAL CHOICE - PREVENTIVE PRIME

REQUIRED OUTLINE OF COVERAGE

A. **Read Your Policy Carefully**. This Outline of Coverage provides a very brief description of some important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of you, your dentist and Delta Dental of Iowa. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

This Certificate does not include all pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available under other Delta Dental of Iowa plans or is available in the Insurance Marketplace.

B. This dental plan is designed to provide an Eligible Covered Person with coverage for diagnostic and preventive benefits. .

C. **BENEFITS -** The information in the two charts below summarizes your benefits and payment obligations.

	DEDUCTIBLE APPLIES*	COINSURANCE	ANNUAL MAXIMUM APPLIES
BENEFIT CATEGORIES	$50 PPO $50 Premier $75 Non-Par		Unlimited
Check-Ups and Teeth Cleaning (Diagnostic and Preventative Services)	Yes	20% - PPO 30% - Premier 50% - Non-Par	Yes
Cavity Repair (Routine and Restorative Services)	Yes	50% - PPO 50% - Premier 70% - Non-Par	Yes

* Deductible is per Eligible Covered Person per Benefit Period.

D. **LIMITATIONS -**

1. **Dental Cleaning (Prophylaxis)** - *Limitation:* Routine dental cleaning is a benefit only twice per Benefit Period.

2. **Oral Evaluations -** *Limitation*: This evaluation is a benefit only twice per Benefit Period.

3. **Topical Fluoride Applications –** *Limitation:* Topical fluoride is a benefit for eligible children under age 15 once every 12 consecutive months.

4. **Bitewing X-Rays -** *Limitation:* Bitewing x-rays are a benefit for eligible children under age 15 once every 12 consecutive months. For an Eligible Covered Person, who is age 15 or older as of the Anniversary Date, bitewing x-rays are a benefit once every 24 consecutive months if there is

no history of restorations in the previous 24 months. If there is a history of restorations in the previous 24 months, bitewing x-rays are a benefit once every 12 consecutive months.

5. **Full-Mouth X-Rays -** *Limitation:* Full-mouth x-rays are a benefit only once every 5 consecutive years.

6. **Occlusal and Extraoral X-Rays -** *Limitation:* These x-rays are a benefit only once every 12 consecutive months.

7. **Sealant/Preventive Resin Applications** – *Limitation:* Sealant/Preventive Resin applications are a benefit once per permanent first and second molars for eligible children under age 19. *Sealants and Preventive Resins for primary teeth, wisdom teeth, or teeth that have already been treated with a restoration are not a benefit.*

8. **Space Maintainers –** *Limitation:* Space maintainers are a benefit only for eligible children under age 15.

9. **Limited Occlusal Adjustment** - *Limitation:* Limited Occlusal Adjustment is a benefit only twice every 12 consecutive months.

E. **EXCLUSIONS**– Even if the treatment is not specifically listed as an exclusion, it may not be covered under this Policy. Call us if you are unsure if a certain service is covered.

1. **Anesthesia or Analgesia -** You are not covered for general anesthesia, intravenous sedation, local anesthesia, non-intravenous conscious sedation, or nitrous oxide (relative analgesia).

2. **Broken Appointments -** You are not covered for any fees charged by your dental office because of broken appointments.

3. **Complete Occlusal Adjustment** - You are not covered for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth.

4. **Complications of a Non-Covered Procedure** - You are not covered for complications of a non-covered procedure.

5. **Congenital Deformities** - You are not covered for services or supplies to correct congenital deformities, such as a cleft palate.

6. **Controlled Release Device** - You are not covered for services or supplies used for the controlled release of therapeutic agents into diseased crevices around your teeth.

7. **Cosmetic in Nature** - You are not covered for services or supplies which have the primary purpose of improving the appearance of your teeth, rather than restoring or improving dental form or function.

8. **Desensitizing Medicament or Resin -** You are not covered for the application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.

9. **Drugs -** You are not covered for prescription, non-prescription drugs, medicines or therapeutic drug injections.

10. **Effective Date -** You are not covered for services or supplies received before the effective date of coverage under this Policy.

11. **Endodontics -** You are not covered for endodontic services including apicoectomy/periradicular surgery, direct or indirect pulp cap, pulpotomy, retrograde fillings, or root canal therapy.

12. **Experimental or Investigative -** You are not covered for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.

13. **Fixed Bridges and Removable Cast Partials –** You are not covered for fixed bridges and removable cast partials.

14. **Government Programs -** You are not covered for services or supplies when you are entitled to claim benefits from governmental programs (except Medicaid).

15. **Gum and Bone Diseases (Periodontal Services)** – You are not covered for services or supplies for periodontal services including conservative, complex, or maintenance periodontal procedures.

16. **High Cost Restorations (Cast Restorations)** – You are not covered for services or supplies for cast restoration services, including crowns, inlays, and onlays.

17. **Implants -** You are not covered for any dental implants which are surgically placed in the jawbone. You are also not covered for the attachment of any device to a surgically placed implant in the jawbone.

18. **Incomplete Services -** You are not covered for dental services that have not been completed.

19. **Infection Control -** You are not covered for separate charges for "infection control," which includes the costs for services and supplies associated with sterilization procedures. Delta Dental Dentists incorporate these costs into their normal fees and will not charge an additional fee for "infection control."

20. **Lost or Stolen Appliances -** You are not covered for services or supplies required to replace lost or stolen dental appliances.

21. **Medical Services or Supplies -** You are not covered for services or supplies which are medical in nature, including dental services performed in a hospital, treatment of fractures and dislocations, treatment of cysts and malignancies, and accidental injuries.

22. **Military Service -** You are not covered for services or supplies which are required to treat an illness or injury received while you are on active status in the military services. However, upon written request, you may ask for a refund of premiums that you have paid while on active military status.

23. **Oral Surgery -** You are not covered for oral surgery including removal of teeth, and other surgical services to the teeth.

24. **Payment Responsibility** - You are not covered for services or supplies when someone else has the legal obligation to pay for your care, and when, in the absence of this Policy, you would not be charged.

25. **Periodontal Appliances -** You are not covered for services or supplies for periodontal appliances (bite guards) to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching.

26. **Periodontal Splinting -** You are not covered for services or supplies used for the primary purpose of reducing tooth mobility, including crown-type restorations.

27. **Plaque Control Programs, Oral Hygiene Instructions, and Dietary Instructions –** You are not covered for services or supplies used for plaque control, oral hygiene, and/or dietary instructions.

28. **Policy Termination** - Whether or not we have approved a treatment plan, you are not covered for treatment received after the coverage termination date of this Policy.

29. **Prosthetics (Bridges, Dentures, and Dental Implants)** – You are not covered for services or supplies used for prosthetics including bridges, dentures, and dental implants.

30. **Provisional Crowns, Bridges or Dentures** - You are not covered for services or supplies for provisional crowns, bridges or dentures.

31. **Repair, Replacement or Duplication of Orthodontic Appliances** - You are not covered for services or supplies required to repair, replace or duplicate any orthodontic appliance.

32. **Root Canals (Endodontics) -** You are not covered for endodontic services including apicoectomy/periradicular surgery, direct and indirect pulp cap, pulpotomy, retrograde fillings, or root canal therapy

33. **Services Not Reimbursed to Some Extent by Delta Dental –** You are not covered for any services that otherwise would qualify as Covered Service but which Delta Dental does not reimburse to some extent. This may include services not reimbursed because of applicable deductibles, copayments, coinsurance, benefit maximums, waiting periods, and frequency limitations.

34. **Services Provided in Other Than Office Setting -** You are not covered for services provided in other than a dental office setting.

35. **Specialized Services -** You are not covered for specialized, personalized, elective materials and techniques or technology which are not reasonably necessary for the diagnosis or treatment of dental disease or dysfunction. Specialized services represent enhancements to other services and are considered optional.

36. **Straighter Teeth – Corrective Orthodontics –** You are not covered for Corrective Orthodontics. Corrective Orthodontic services are orthodontic procedures, or directly associated procedures, that move teeth to correct an abnormal dental relationship between and among teeth.

37. **Temporary or Interim Procedures** - You are not covered for temporary or interim procedures.

38. **Temporomandibular Joint Dysfunction (TMD) -** You are not covered for expenses incurred for diagnostic x-rays, appliances, restorations or surgery in connection with Temporomandibular Joint Dysfunction or myofunctional therapy.

39. **Tissue Conditioning –** You are not covered for services or supplies pertaining to tissue conditioning.

40. **Tooth Extractions –** You are not covered for tooth extractions.

41. **Treatment By Other Than A Licensed Dentist -** You are not covered for services or treatment performed by anyone other than a licensed dentist or his or her employees.

42. **Unerupted Teeth -** You are not covered for the prophylactic removal of unerupted teeth (asymptomatic and nonpathological). This means we will not pay for the removal of any tooth that is not visible and not causing harm.

43. **Workers' Compensation -** You are not covered for services or supplies that are or could have been compensated under Workers' Compensation laws, including services or supplies applied toward satisfaction of any Deductible under your employer's Workers' Compensation coverage.

F. **POLICY RENEWAL** – Your coverage under the Policy will continue unless one of the following events occurs:

1. You fail to make your premium payment to us when due.
2. You become ineligible for coverage under the Policy.
3. You decide to discontinue or replace this coverage - *Delta Dental of Iowa requires at least **20-day written** notice prior to the requested termination.*
4. We decide to terminate coverage of all similar Policies by giving written notice to you 90 days prior to termination.
5. You use the Policy fraudulently or you fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payments we made, minus any premiums paid.
6. You are no longer a permanent resident of Iowa.

G. **PREMIUMS** – You must pay us the full amount of your premium in advance of the due date assigned for your Policy. For example, payment must be made prior to the beginning of each calendar month, via automatic withdrawal (ACH) from a checking or savings account or with a valid credit card (American Express, Discover Card, Master Card, or VISA).

H. **OTHER INFORMATION –**

Claims filing address – Delta Dental of Iowa; P.O. Box 9000; Johnston, IA 50131-9000
Hearing Impaired Toll Free – 1 – 888 – 287- 7312
Toll Free – 1 – 800 – 544 – 0718 **Local –** 1– 515 – 261 – 5500
Delta Dental of Iowa's website –

- www.deltadentalia.com
- claims@deltadentalia.com
- individualproduct@deltadentalia.com